STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		X2) MULTIPLE CONSTRUCTION X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 03/30/2010)	
	PROVIDER OR SUPPLIE		2400 C	ADDRESS, CITY, STATE, ZIP COD COLLEGE AVE EN, IN 46526	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE ROPRIATE COI	(X5) MPLETION DATE
F 0000 Bldg. 00	Complaint IN00 Complaint IN00 Federal/State de F157 and F282. Survey dates: M Facility number Provider number AIM number: 1 Census bed type SNF: 7 SNF/NF: 164 Total: 171 Census payor ty Medicare: 8 Medicaid: 126 Other: 37 Total: 171 Sample: 3 These deficience cited in accordat 16.2-3.1.	0195394 - Substantiated. efficiencies are cited at March 29 and 30, 2016. :: 000091 er: 155689 00290080 e:	F 0000			
	Quality Keview	Competed by 14454 Off				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000091

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155689	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction <u>00</u>	(x3) date survey COMPLETED 03/30/2016
	ROVIDER OR SUPPLIER ARD HEALTHCARE CENTER	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	April 5, 2016.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights			
	under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically			
	update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to ensure a physician's	F 0157	Please accept this Plan of Correction as our facility's Credible Allegation of complian	04/06/2016 nce

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	A. BUILDING 00		COMPLETED	
		155689	B. W	B. WING 03/30/2016			
		1.23000				30,007	.
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					OLLEGE AVE		
COURTY	'ARD HEALTHCAF	RE CENTER		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	order was clarif	ied timely for one of three			for our Recertification and Sta		
	residents review	yed who was in need of a			Licensure Survey concluded		
	clarification for	an admission medication			March 30, 2016. Submission		
	order. (Residen				this Plan of Correction is not a	an	
	order. (Residen	(В)			admission by Courtyard Healthcare Centerthat the		
					deficiencies alleged in the sur	nvov.	
	Finding include	s:			are accurate or that they depi	,	
					the quality of nursing care an		
	On 3/29/16 at 1:	:30 P.M., the clinical			services provided to the resid		
	record for Resid	lent B was reviewed.			of our facility. This plan of		
		admitted to the facility			correction is being submitted		
		ignoses included but were			solely because doing so is		
		· ·			required by state and federal		
	· · · · · · · · · · · · · · · · · · ·	therosclerotic heart			Considering the volume, scor	oe,	
	disease of native	e coronary artery with			and severity of the alleged		
	unspecified ang	ina pectoris, transient			deficient practices noted in th		
	cerebral ischem	ic attack, unspecified, and			CMS-2567, Courtyard Health		
		artery syndrome.			Center respectfully requests a desk review for this survey. I		
	, 6106010 0 0 0 0 1 0 1	arvery symmetric.			approved, we would be willing		
	A (1 hit-1) - dii			provide any and all	, .0	
		al hospital) admission			documentation requested		
	· ·	4/16 at 9:25 A.M.,			including, but not limited to:		
	indicated "Rand	olazine [Ranexa - an			education records, policies ar	nd	
	antianginal med	ication] 1,000 MG			procedures, check lists, and		
	[milligram] tab	[tablet] er [extended			forms that have been comple		
	release] 12h [ho				revised or implemented as pa		
	, ,	Daily At Bedtime"			this plan of correction. F 15	7	
	iviiliigiaili Olal	Dany At Deathing			NOTIFY OF CHANGES		
	.	1.001636.1			(INJURY/DECLINE/ROOM,E	IC)	
		arch 2016 Medication			This facility will immediately	ith	
	Administration	Record (MAR), indicated			inform the resident; consult w the resident's physician; and		
	the first dosage	of Ranexa 1000 mg at			known, notify the resident's le		
	bedtime was no	t documented as			representative or an intereste		
		tween the dates of			family member when there is		
	2/14/16 and 2/1				accident involving the resider		
	2/14/10 and 2/1	0/10.			which results in injury and ha		
					potential for requiring physicia		
	The nursing pro	gress notes, dated 2/14/16			intervention; a significant cha	nge	
	through 2/25/16	lacked any			in the resident's physical, me	ntal,	

i i		f '			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1	A. BUILDING 00			COMPLETED	
155689			B. Wl	ING		03/30/	2016	
NAME OF F	DROWIDED OF CLIPPI IED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			2400 C	OLLEGE AVE			
COURTY	ARD HEALTHCAR	E CENTER		GOSHE	EN, IN 46526			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	documentation re	elated to the notification			or psychosocial status (i.e., a			
	of the on call do	ctor, the primary			deterioration in health, mental psychosocial status in either li			
	physician for Re	sident B or any new			threatening conditions or clinic			
	physician orders	related to the			complications); a need to alter			
		f Renexa at bedtime.			treatment significantly (i.e., a			
					need to discontinue an existing			
	During an interv	iew conducted with LPN			form of treatment due to adver			
	_	cal Nurse) #1 on 3/30/16			consequences, or to commend	e a		
	`	'N #1 indicated she was			new form of treatment);or a decision to transfer or discharge	10		
	· ·				the resident from the facility.	,.		
		as working with Resident			This facility will also promptly			
		nis admission to the			notify the resident and the			
	facility. She ind	icated when she			resident's legal representative			
	reviewed Reside	nt B's admission orders			interested family member whe	n		
	she noted that he	had not received the			there is a change in room or			
	Ranexa 1000 mg	dose at bedtime while			roommate assignment as			
	_	nd she thought this was a			specified in 483.15(e)(2);or a change in resident rights unde	r		
		for him and at such a			Federal or State law or	•		
		estioned whether or not			regulations as specified in			
		hould be administered.			paragraph (b)(1) of this section	١.		
					The facility will record and			
		d the on call doctor was			periodically update the address	S		
		rification orders on			and phone number of the resident's legal representative	or		
		loctor did not clarify the			interested family member.	OI		
		ted Resident B's primary			Corrective Action: Resident B	3		
	physician should	have been contacted to			no longer resides at this facility			
	clarify the order.	LPN#1 indicated			How others are identified: Al	I		
	Resident B's prin	nary physician was			residents have the potential to			
	_	5/16 with no response.			affected bythis alleged deficier	nt		
		d she did not document			practice.			
		of the on call physician or			PreventativeMeasures: Licensed nurses were educate	·d		
		ntact the primary care			on notification of changes relat			
	^	medical record she			to new admissions/readmission			
					and clarification of orders with	the		
		attempts on the 24 hour			attending physician. An			
	_	N#1 indicated she did			additional section was built into)		
	not know if any	further attempts to			our admission assessment to			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING X3) DATE SURV COMPLETED 03/30/2010					
155689		B. WI	NG		03/30/	2016	
	PROVIDER OR SUPPLIEI		-	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
	were made. On 3/30/16 at 9: report sheets, da were reviewed. physician had be need to clarify th but did not indic physician related the medication of clarification from On 3/30/16 at 10 was conducted of Nurses (DON). she had reviewe record and did in documentation of the primary care in the clinical re the resident's pri instruction on 2/ administration of bedtime but that in the nurses not physicians order she did not know to notify the resi were made betw but that in the pa doctor a long tin communication	of the on call doctors or physicians notification cord. She indicated that mary care physician gave			provide our nurses the opportunity to document the information. Monitoring: The Director of Nursing/Designee of monitor admission/readmission/documentation for physician notification and medication clarification on incoming residents. This audit will conting for 6 months. Results of this at will be presented to QAPI for need for further monitoring. Dateof Completion: April 6, 2016.	n nue	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		(X2) MULT A. BUILL B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 03/30/	ETED	
	ROVIDER OR SUPPLIER		2	2400 CC	DDRESS, CITY, STATE, ZIP CODE DLLEGE AVE N, IN 46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX ΓAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION DATE
	either hold or dis	would be obtained to scontinue the medication on order could be					
	provided the curr Orders," effectiv The policy indica Any dose or orde inappropriate con age, condition, a	45 A.M., the DON rent policy, "Medication e date January 2007. ated "ProceduresB. er that appears nsidering the resident's llergies, or diagnosis is attending physician"					
	This Federal tag 00195394.	relates to Complaint IN					
	3.1-5(a)(1)						
F 0282 SS=D Bldg. 00	CARE PLAN The services provifacility must be propersons in accordance written plan of care	ance with each resident's	F 0282	2	Please accept this Plan of		04/06/2016
	the facility failed	to ensure the plan of			Correction as our facility's Credible Allegation of complian	nce	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00		COMPLETED	
		155689	B. WING 03/30/2016			03/30/2016	
				CTREET	ADDRESS SITY STATE TIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
					OLLEGE AVE		
COURTY	ARD HEALTHCA	RE CENTER		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	care was follow	yed for a resident who was			for our Recertification and Sta	te	
	to receive a pre	scribed medication for			Licensure Survey concluded		
	-	idents reviewed.			onMarch 30, 2016. Submission		
		idents reviewed.			of this Plan of Correction is no	t an	
	(Resident B)				admission by Courtyard		
					Healthcare Center that the		
	Finding include	es:			deficiencies alleged in the sur are accurate or that they depic		
					the quality of nursing care and		
	On 3/29/16 at 1	:30 P.M., the clinical			services provided to the reside		
		dent B was reviewed.			of our facility. This plan of		
		admitted to the facility			correction is being submitted		
		•			solely because doing so is		
		agnoses included but were			required by state and federal		
	not limited to, a	therosclerotic heart			law. Considering the volume		
	disease of nativ	e coronary artery with			scope, and severity of the alle	ged	
	unspecified ang	gina pectoris, transient			deficient practices noted in		
		ic attack, unspecified, and			theCMS-2567, Courtyard		
		artery syndrome.			Healthcare Center respectfully		
	Vertebro-basilar	artery syndrome.			requests a desk review for this survey. If approved, we woul		
		11			be willing to provide any and a		
	_	al hospital] admission			documentation requested		
	order, dated 2/1	4/16 at 9:25 A.M.,			including, but not limited to:		
	indicated " Ran	olazine [Ranexa, an			education records, policies an	d	
	antianginal med	lication] 1,000 MG			procedures, checklists, and fo		
	_	[tablet] er [extended			that have been completed,		
	1	our] Dose: 1,000			revised or implemented as par	rt of	
		•			this plan of correction F 282		
	Milligram Oral	Daily At Bedtime"			SERVICES BY QUALIFIED		
					PERSONS/PER CARE PLAN		
	Resident B's M	arch 2016 Medication			Services provided or arranged		
	Administration	Record (MAR), indicated			this facility will be provided by		
		of Ranexa 1000 mg at			qualified persons in accordance		
	_	of documented as			with each resident's written plant of care. Corrective Action:		
		etween the dates of			Resident B no longer resides		
					this facility. How others are	•	
	2/14/16 and 2/1	8/16.			identified: All residents have	•	
					potential to be affected by this	•	
	The nursing pro	ogress notes, dated 2/14/16			alleged deficient practice.		
	through 2/25/16	_			Preventative Measures		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	î ´	UILDING	onstruction 00	(X3) DATE : COMPL 03/30/	ETED
	PROVIDER OR SUPPLIER		•	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	of the on call doephysician for Rephysician orders administration of During an interv (Licensed Practicat 9:30 A.M., LF the nurse who were B at the time of I facility. She indreviewed Reside she noted that here Ranexa 1000 mg in the hospital armew medication high dose she que the medication since LPN #1 indicated contacted for clate 2/14/16, but the order and indicated physician should the order. LPN# primary physiciated 2/15/16 with noting in the documented hermal report sheet. LP	related to the f Renexa at bedtime. iew conducted with LPN cal Nurse) #1 on 3/30/16 PN #1 indicated she was as working with Resident his admission to the			Licensed nurses were educate on notification of changes relate to new admissions/readmission and clarification of orders with attending physician. An additional section was built intour admission assessment to provide our nurses the opportunity to document the information. Monitoring: The Director of Nursing/Designeers monitor admission/readmission documentation for physician notification and medication clarification on incoming residents. This audit will contifor 6 months. Results of this audit will be presented to QAF for need for further monitoring Date of Completion: April 6, 2016.	ted ins the o	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		2) MULTIPLE COI A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/30/2016
NAME OF PROVIDER OR SUPPLIER	•		DDRESS, CITY, STATE, ZIP CODE	
COURTYARD HEALTHCARE CENTER	२		N, IN 46526	
(X4) ID SUMMARY STATEMENT (PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTI	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
contact Resident B's prima were made.	ary physician			
On 3/30/16 at 9:45 A.M., report sheets, dated 2/14/1 were reviewed. Each sheet physician had been notified need to clarify the Renexa but did not indicate any in physician related to the add the medication while wait clarification from the primary care instruction on 2/19/16, for administration of Renexa bedtime but that it was not in the nurses notes it was applysicians order. She indicated in the serious conduction of the one of the primary care instruction on 2/19/16, for administration of Renexa bedtime but that it was not in the nurses notes it was applysicians order. She indicate the serious care in the clinical record.	6 and 2/15/16, et indicated the d related to a 1000 mg order struction by the ministration of ing for early physician. an interview irector of indicated that the B's clinical y all doctors or as notification indicated that ephysician gave the 1000 mg at the documented written as a			
not know if any further att the resident's primary phy made between 2/15/16 and that in the past it takes this doctor a long time to respo communication and that h would be that if an order r	seempts to notify sician were 1 2/19/16, but s particular and to facility er expectation			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
	155689	B. WING		03/30/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
			OLLEGE AVE		
COURTY	ARD HEALTHCARE CENTER	GOSHE	EN, IN 46526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
TAG	clarified a order would be obtained to	TAG	BEHOLD CT /	DATE	
	either hold or discontinue the medication				
	until a clarification order could be				
	obtained.				
	Commod.				
	On 3/30/16 at 8:45 A.M., the DON				
	provided the current policy, "Medication				
	Orders," effective date January 2007.				
	The policy indicated "ProceduresB.				
	Any dose or order that appears				
	inappropriate considering the resident's				
	age, condition, allergies, or diagnosis is				
	verified with the attending physician"				
	This Federal tag relates to Complaint				
	IN00195394.				
	3.1-35(g)(2)				

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